INFORMATION

Proposals of the Medical Task Force and of the Hoover Commission

A GREAT DEAL of comment already has been brought forth upon recommendations made to the Congress by the Committee on Organization of the Executive Branch of the Government for changes in the Health and Medical services of the Federal Government. Hence the sources and derivations of those recommendations become a matter of interest.

The changes proposed are one aspect of the assignment given to the Commission by congressional action. That assignment was to carry out studies and make recommendations with a view to promoting economy and improving efficiency of service by various departments in the Executive Branch of the Government. The Commission—headed by former President Herbert Hoover and popularly called the Hoover Commission—divided its work among a number of Task Forces, each made up of experts in the specific field to be studied.

TASK FORCE PERSONNEL

The personnel of the Task Force on Federal Medical Services, appointed by the Hoover Commission, is:

Chairman, Chauncey McCormick (deceased September 8, 1954); Theodore G. Klumpp, M.D., President, Winthrop-Stearns, Inc., New York, N. Y. (appointed September 26, 1954 to replace Mr. McCormick).

Assistant Chairman, Edwin L. Crosby, M.D., director, American Hospital Association, Chicago, Illinois.

Members:

Francis J. Braceland, M.D., psychiatrist-in-chief, Institute of Living, Hartford, Conn., and clinical professor of psychiatry, Yale University, New Haven, Conn.

Otto W. Branhorst, D.D.S., secretary, American College of Dentists, St. Louis, Mo.

Edward D. Churchill, M.D., chief surgeon, Massachusetts General Hospital, and Harvard University Professor, Boston, Mass.

Michael E. DeBakey, M.D., chairman, Department of Surgery, Baylor University, College of Medicine, Houston, Texas.

Evarts A. Graham, M.D., emeritus professor of surgery, Washington University School of Medicine, St. Louis, Mo.

Alan Gregg, M.D., vice-president, Rockefeller Foundation, New York, N. Y.

Paul R. Hawley, M.D., the director, American College of Surgeons, Chicago, Ill.

Hugh R. Leavell, M.D., professor of public health practice, Harvard School of Public Health, Boston, Mass.

Basil C. MacLean, M.D., commissioner of hospitals, New York, N. Y.

Walter B. Martin, M.D., chief of medicine, St. Vincent's Hospital, Norfolk, Va., and president, American Medical Association.

James Roscoe Miller, M.D., president, Northwestern University, Evanston, Ill.

Dwight L. Wilbur, M.D., clinical professor of medicine, Stanford University, San Francisco.

Milton C. Winternitz, M.D., former chairman, Division of Medical Sciences, National Research Council, Washington, D. C.

SCOPE AND METHODS OF STUDY

The medical service functions of the Government studied by the Task Force were:

1. Medical care.
2. Hospital construction.
3. Research in the field of health.
4. Preventive health services.
5. Grants-in-aid to state health programs.
6. Assistance to international health programs.
7. Regulation of foods and drugs.
8. Education and training for health personnel.
9. Medical supply.
10. Organization for disaster.

The Task Force collected information from many sources, including:

1. Reports, interviews and correspondence with representatives of government agencies.

2. Reports, interviews and correspondence with representatives of nongovernment organizations and informed individuals.

3. Answers to formal questionnaires directed to federal agencies.

4. Field studies of federal medical and dental care and medical supply installations.

5. Reports of the previous Hoover Commission and other commissions and study groups.

In its study the Task Force analyzed and interpreted both fact and opinion. When the need arose, it called upon the services of expert consultants, including those in medical education, voluntary sickness insurance, and dental care. However, the

entire Task Force considered the evidence before making any recommendations.

Many of the proposals made by the Task Force were adopted by the Hoover Commission as recommendations when the commission made its report to Congress. Others were changed considerably before being submitted as recommendations. Some the commission omitted from its recommendations.

As a part of its report to the Hoover Commission, the Task Force included an estimate of the fiscal effect of its proposals if they were implemented. Some of the proposed changes, it was estimated, would bring about a reduction in government outlays for medical, hospital and disability services. Other proposals would create new services and add to costs. However, it was estimated that the net effect of following all the proposals of the Task Force would be a reduction of approximately $300,000,000 annually in government expenditures (see Table 1).

PROPOSALS AND RECOMMENDATIONS

Following is a resume of the Task Force proposals and of the action on them by the Hoover Commission:

TABLE 1.—*Estimated fiscal effect of changes proposed by Medical Task Force*

Specific areas in which savings would be effected:	
Limitations of hospital care benefits for veterans with no service-connected disability	$150,000,000
Termination of service to merchant seamen	12,000,000
Closing of certain VA hospitals	7,500,000
Coordination of medical supply activities	20,000,000
Reorganization of Food and Drug Administration activities	1,000,000
Change of meat inspection to sampling basis	4,000,000
Reduction of ratio of physicians and dentists in Armed Forces	15,000,000
Improved administration of disability allowances by Veterans' Administration	180,000,000
Regionalization of military medical services	10,000,000
TOTAL	$399,500,000
Specific areas for which increased expenditures are needed:	
A National Council of Health	$ 200,000
A National Library of Medicine	*1,000,000
Health insurance coverage rather than direct medical care to dependents of military personnel	25,000,000
Health insurance for federal civilian employees	55,000,000
Grants to states for health purposes	15,000,000
Research and training grants in psychiatry, and grants to states for community mental health programs	5,000,000
Assistance to school of public health	5,000,000
TOTAL	$106,200,000
ESTIMATED SAVING, NET	$293,300,000

*Operating expense only. Six million dollars is needed for construction.

FEDERAL ADVISORY COUNCIL ON HEALTH

1. *Task Force Proposal:* To provide continuing coordinated planning and operation of widely dispersed health activities of the Federal Government, legislation should be enacted to establish within the Executive Office of the President a Federal Council of Health charged with the recommendation and continuous evaluation of policy governing the health activities of the Federal Government.

Commission Action: **Substantially accepted as recommendation. (As an alternative it recommended that "in the event the proposed Federal Advisory Council on Health is not created, the President assign the functions of review and advice proposed for it to other agencies.")**

A NATIONAL LIBRARY OF MEDICINE

2. *Task Force Proposal:* Legislation to create and maintain a National Library of Medicine and to transfer to it the collections and the activities of the present Armed Forces Medical Library.

Commission Action: **Accepted as recommendation.**

RESEARCH FOR HEALTH

3. *Task Force Proposal:* That the present system of project grants for research pertinent to health be modified and that it be gradually replaced by a system of five-year block grants to institutions or agencies which would be made in accordance with an approved over-all plan for health research submitted by each; and

That the Federal Council of Health be given responsibility for facilitating the health research programs of the Federal Government, utilizing the National Research Council of the National Academy of Sciences as staff.

Commission Action: **Substantially accepted as recommendation, but no mention made of National Research Council.**

DEPENDENTS OF MILITARY PERSONNEL

4. *Task Force Proposal:*

(a) That the Federal Government continue to carry the responsibility for the provision of medical and hospital care in overseas areas for dependents of military personnel; and

(b) That the Federal Government shall develop for dependents of military personnel within the continental United States a contributory program of medical and hospital insurance for in- and outpatient medical care and hospitalization; participation to be on a voluntary basis.

Commission Action: **Substantially accepted as recommendation.**

VETERANS

5. *Task Force Proposal:* That all existing rules, regulations, executive orders and laws relating to veterans or veterans' benefits, and in particular to

medical treatment and domiciliary care benefits, be consolidated and enacted into a single, all-inclusive, comprehensive code; and

That the Congress enact legislation to provide that veterans receive:

(a) Hospital care for nonservice-connected disabilities if medical need for such disabilities was established within three years after separation from service; and

(b) Outpatient care following hospitalization for those nonservice-connected disabilities for which medical need was established at the time the veteran was hospitalized.

6. *Task Force Proposal:* That the Veterans Administration, within its present facilities, emphasize its program of medical care and rehabilitation services for the aging veteran.

***Commission Action* (on Proposals 5 and 6): As to consolidation of laws the Commission concurred. With regard to eligibility for care of nonservice-connected disability, the Commission took the position that "the sentiment of the American people is that a sick and really indigent veteran should be provided care in VA hospitals." It recommended more stringent scrutiny of inability to pay, and provision for collection in the future. The Commission recommended that out-patient care be provided *prior* to hospitalization, as well as after, for the indigent veteran (excluding psychiatric care prior to hospitalization).**

MERCHANT SEAMEN

7. *Task Force Proposal:* That [in light of the fact that the merchant marine is largely a private enterprise] legislation be enacted to end within a reasonable period the federal subsidy to the merchant marine through the provision of medical and hospital services to merchant seamen; and

That pending such termination the Public Health Service and other concerned agencies of the Federal Government cooperate with the merchant marine in developing a program to provide medical and hospital care for merchant seamen in civilian facilities through voluntary health insurance plans.

***Commission Action:* For merchant seamen, the Commission recommends termination of care. No reference is made to developing an alternate program. The Commission also recommends care of PHS Commissioned Corps, Coast and Geodetic Survey, and Coast Guard and their dependents in military hospitals, with insurance to be developed for dependents, as with the military. PHS general hospitals to be closed.**

FEDERAL EMPLOYEES

8. *Task Force Proposal:* That Congress enact legislation under which the Federal Government would develop for its employees on a voluntary prepayment basis a program of contributory medical and hospitalization insurance based upon the utilization of payroll deduction.

***Commission Action:* Recommended development of a plan by the executive branch of the Government through a pool of private health insurance agencies, the Government to pay part of the cost.**

DENTAL SERVICES FOR MILITARY AND DEPENDENTS

9. *Task Force Proposal:* That in the military departments emphasis be placed on comprehensive dental care for active duty career personnel, and reduced to a minimum for other active duty [short term] and retired personnel; and

That dental care for dependents, other than those at overseas installations, be limited to emergency service.

***Commission Action:* Omitted from report.**

HOSPITALS AND HOSPITAL CONSTRUCTION

10. *Task Force Proposal:* That the Veterans Administration close and dispose of by sale or otherwise any hospital which in its judgment can no longer be operated effectively or economically; and

That Congress authorize no further construction of Veterans Administration hospitals.

***Commission Action:* Recommended essentially as proposed.**

11. *Task Force Proposal:* That programs for the construction of hospitals and other medical care facilities of all federal agencies be subject to the approval of the Federal Council of Health, with a view to developing joint planning among all agencies affected—nonfederal as well as federal;

That the Council recommend policies for the hospital survey and construction program as it relates to federal hospitals; and

That the Council study the effect of the hospital survey and construction program to evaluate such problems as the regionalization of hospital services, the minimum size of an effective hospital facility, and particularly the relation of the small community hospital to the total hospital program.

***Commission Action:* No recommendation.**

MEDICAL SUPPLY

12. *Task Force Proposal:* That joint procurement of medical supplies for all departments and agencies of the Federal Government be assigned to a single agency, and that this agency establish a single federal medical supply catalog and a uniform system of medical stock accounting within the Government; and

That there be established two systems within the Federal Government for integrated storage and distribution of medical supplies; that the military system comprise the Army, Navy, Air Force, Coast Guard, and Federal Civil Defense Administration;

that the civilian system comprise all other federal agencies and be administered by the Veterans Administration on their behalf; and that both systems provide for ownership of medical material by the major using agency.

***Commission Action:* Discussion only. Recommendation to be made in Commission's report on Procurement.**

SERVICES FOR THE HEALTH OF THE PUBLIC

13. *Task Force Proposal:* That the Federal Government give greater emphasis to preventive health services, including those rendered in connection with medical care of federal beneficiaries, in the interests of both health conservation and long-range economy.

***Commission Action:* Accepted as recommendation but gave responsibility to Federal Advisory Council of Health.**

14. *Task Force Proposal:* That the Federal Council of Health examine means of establishing cooperative planning among federal agencies providing psychiatric care;

That the military services develop special facilities for the study and prevention of mental disorders among military personnel;

That the Veterans Administration give greater emphasis to preventive psychiatric services; and

That the Federal Government, through the Public Health Service, help to meet the problems of mental disease by:

(a) Increased grants to the states to help communities participate in the development of outpatient and child health clinics for mental illness;

(b) Increased research grants to universities and other research centers for investigation of mental health and disease; and

(c) Continued and expanded grants for advanced training for psychiatrists and workers in allied fields, with emphasis on residences and fellowships.

***Commission Action:* Recommended but omitted increased grants and community service programs.**

15. *Task Force Proposal:* That the Federal Government strengthen state health programs by maintaining federal grants for health at least at the average level of the years 1948 to 1953, by emphasizing grants for general health purposes (as distinguished from categorical purposes), and by allowing each state to transfer among categories a reasonable proportion of such grants; and

That the Federal Government authorize and encourage states to use a larger share of the grants for the training of health workers, the evaluation of state and local health programs, and the strengthening of local health services.

***Commission Action:* Recommend that the Secretary of Health, Education and Welfare consider the problem of "specific federal grants."**

16. *Task Force Proposal:* That the United States adopt a long-term policy in the field of international technical assistance, relating health work to agriculture and education as closely as possible and divorcing it from military assistance;

That multilateral international programs gradually supersede, where practicable, programs involving the United States and only one other country; and

That evaluation of the programs be augmented and carried out on a continuing basis.

***Commission Action:* Omitted from report.**

17. *Task Force Proposal:* That the Department of Health, Education, and Welfare make a detailed examination of the policies, programs, and operations of the Food and Drug Administration with a view to curtailing those functions that are no longer essential and augmenting those that have become increasingly important.

***Commission Action:* Recommended joint Health, Education and Welfare, Department of Agriculture, and Budget Bureau study of functions.**

18. *Task Force Proposal:* That the functions and activities of the Agricultural Research Service, Department of Agriculture, relating to the control of pesticides be transferred to the Food and Drug Administration; and

That the functions and activities of the Livestock Regulatory Division of the Agricultural Research Service, Department of Agriculture, relating to the regulation of biological products, be transferred to and combined with the biological regulatory work of the National Institutes of Health.

***Commission Action:* Omitted from report.**

19. *Task Force Proposal:* That the Department of Agriculture change its unit inspection of meat to a system based on scientific sampling and place increased emphasis on factors concerned with environmental sanitation; and

That similar principles and practices be applied to poultry.

***Commission Action:* Omitted from report.**

HEALTH MANPOWER FOR PUBLIC SERVICE

20. *Task Force Proposal:* That the Doctor Draft law (Public Law 84, 83rd Cong.) not be extended or reenacted. Any legislation extending or reenacting the basic Selective Service law should provide that registrants under such law who are or become physicians or dentists be placed in categories separate from other registrants, and that separate levies be placed on the states for these categories.

21. *Task Force Proposal:* That the Assistant Secretary of Defense (Health and Medical), with the advice of the Federal Council of Health, establish ratios of physicians and dentists on active duty to each 1,000 active duty personnel; and that for the

present this ratio not exceed 3 physicians and 1.7 dentists for the three Armed Services taken together, though it may be different for each of the services.

Commission Action: **Language of Commission was less specific. Its recommendation was for "revision of Selective Service Act to effect maximum utilization of medical personnel."**

22. *Task Force Proposal:* That the Armed Services training programs for interns and residents, for other physicians and dentists on active duty, and for reserve officers not on active duty be strengthened, and be planned and directed from the medical center of each service, using selected military and civilian hospitals for special training.

Commission Action: **Recommended essentially as proposed.**

23. *Task Force Proposal:* That the Public Health Service Commissioned Corps be utilized more extensively as a central pool of professional health personnel to be detailed to other units of the Department of Health, Education, and Welfare and to other agencies to fill essential positions in the field of health.

Commission Action: **Omitted from report.**

24. *Task Force Proposal:* That within the Federal Government the transfer and cross-agency assignment of health personnel—including those in the military services, the Public Health Service Commissioned Corps, and the Veterans Administration's Department of Medicine and Surgery—be facilitated by appropriate changes in laws, regulations, and organizational policies and that some agency, presumably the proposed Federal Council of Health, reexamine the necessity for the several systems for health personnel.

Commission Action: **Recommended essentially as proposed.**

25. *Task Force Proposal:* That federal financial assistance be provided to schools of public health on the graduate level only:

(a) By block grants in amounts dependent upon the number of students graduating from the school and entering federal, state, and local government service or service of the government of another nation in the most recent previous five-year period, with such grants not exceeding the actual cost of education involved; and

(b) On a matching basis for capital outlays.

Commission Action: **Omitted from report.**

THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

26. *Task Force Proposal:* That the Department of Health, Education, and Welfare provide more leadership and assume more responsibility in planning and carrying out the programs of the Federal Government that relate to civilian health, exploring sound means within public policy of assisting the American people to improve their own health.

27. *Task Force Proposal:* That the present post of Special Assistant for Health and Medical Affairs to the Secretary of the Department of Health, Education, and Welfare be elevated to the post of Assistant Secretary for Health.

28. *Task Force Proposal:* That St. Elizabeth's Hospital be made a part of the Public Health Service hospital system.

29. *Task Force Proposal:* That the Children's Bureau be removed from the Social Security Administration and placed in an administrative position in the Department of Health, Education, and Welfare that will facilitate the major mission of the Bureau. This mission is to take cognizance of the needs of the whole child in the broad fields of health, education, and welfare, to support the necessary research in the field, and to stimulate the utilization of new knowledge by the various agencies of the Federal Government within and outside the Department of Health, Education, and Welfare and in the states.

30. *Task Force Proposal:* That Freedmen's Hospital and Howard University remain, for the present, under the general supervision of the Department of Health, Education, and Welfare and that the department exercise its influence to improve the facilities and operational standards of Freedmen's Hospital and Howard University's college of medicine, dentistry, and pharmacy, including a determination as to how the University and Freedmen's Hospital may be placed on an independent basis.

Commission Action **(on Proposals 26-30): Omitted from report.**

VETERANS ADMINISTRATION

31. *Task Force Proposal:* That the medical care functions of Veterans Administration regional offices be consolidated with, and, where practicable, physically located within nearby Veterans Administration hospitals.

Commission Action: **Recommended essentially as proposed.**

32. *Task Force Proposal:* That the Department of Medicine and Surgery of the Veterans Administration be given the responsibility and authority to establish and maintain:

(a) The medical criteria for disability, both initial and continuing, and

(b) A mechanism for more frequent review of disability allowances which recognizes the possibility of partial or complete rehabilitation from disability.

Commission Action: **Recommended essentially as proposed.**

DEFENSE DEPARTMENT

33. *Task Force Proposal:* That the Office of the Assistant Secretary of Defense (Health and Medical) be strengthened by:

(a) The establishment of a civilian position of Deputy Assistant Secretary of Defense (Health and Medical); and

(b) Augmentation of the technical and analytical staff of the Office of the Assistant Secretary of Defense (Health and Medical) to meet its increased responsibilities.

Commission Action: **Omitted from report. (However, a civilian deputy to the Assistant Secretary was appointed recently.)**

34. *Task Force Proposal:* That the medical service of each of the military departments be given a position in the departmental organizational structure commensurate with its over-all responsibility for health and medical care, and that each of the Surgeons General be given reasonably comparable authority to include:

(a) Technical and management control (but not necessarily military control) of all medical activities and operations.

(b) Control of the assignment and activities of all medical service personnel, including enlisted personnel.

(c) Control of funds commensurate with his over-all program and mission responsibility.

Commission Action: **No recommendation. Discussed in text only.**

35. *Task Force Proposal:* That the medical and hospital services of the three Armed Forces be modified into a much more closely coordinated pattern which will provide that:

(a) The military medical and hospital services within continental United States be coordinated by assigning to a single military department the responsibility for hospital service in a defined geographic area and that this concept be furthered, wherever practicable, in extracontinental areas;

(b) Patients of all military departments requiring highly specialized medical care be concentrated into special hospitals, each of which will serve the three departments;

(c) Each of the three military departments maintain a medical center, the components of which should be a hospital, a center for postgraduate education in military medicine and a research institute occupied with medical problems identified with the primary mission of the department; and

(d) The Assistant Secretary of Defense (Health and Medical) be given authority to modify and reallocate medical care responsibilities of the three departments in line with the above.

Commission Action: **Recommended essentially as proposed.**

ORGANIZATION FOR DISASTER

36. *Task Force Proposal:* That the Federal Civil Defense Administration be given greater statutory authority and financial support to plan, coordinate, and operate national, state, and local civil defense plans, and that its Health Office be elevated in organizational status to a position commensurate with its duties and responsibilities; and

That plans be made for the delegation of operational authority for directing emergency medical care during and immediately following an attack on continental United States to the Department of Defense, in close cooperation with the Department of Health, Education, and Welfare and Federal Civil Defense Administration.

Commission Action: **Recommended that "the Federal Government . . . should include in its consideration of the problem the question of appropriate delegation of operational authority for directing medical care." The Commission did not mention any federal agency by name.**

Group Practice Under a Fictitious Name

FOLLOWING is an opinion of the Attorney General of California regarding the legality of the group practice of physicians under a fictitious name.

Opinion of Edmund G. Brown, Attorney General; E. G. Funke, Assistant Attorney General
No. 54/10

MR. WALLACE W. THOMPSON, executive secretary of the Board of Medical Examiners of the State of California, has requested our interpretation of Business and Professions Code sections 2393 and 2429 with relation to the following specific questions:

1. May a group of persons, licensed as physicians and surgeons, form a partnership and practice medicine under a fictitious name?

2. May a group of persons, licensed as physicians and surgeons, form a partnership with other licentiates of the healing arts and practice under a fictitious name?

Our conclusions may be summarized as follows:

1. Physicians and surgeons may form a partnership and practice medicine under a fictitious name, provided the partnership name includes the surname of at least one partner followed by the words "Medical Group."

2. Physicians and surgeons may not form a partnership with other licentiates of the healing arts and practice under a fictitious name.

ANALYSIS

The Medical Practice Act (now found in chapter 5 of division 2 of the Business and Professions Code) formerly prohibited the practice of medicine by a physician and surgeon under any type of fictitious name. The State sought to give assurance to the general public that when a person called upon a physician and surgeon for professional advice, he would be reasonably assured of a doctor-patient relationship and would be further assured that none other than physicians and surgeons would treat him without his knowledge (see *Berry* v. *Alderson*, 59 Cal. App. 729, 732, 211 Pac. 836, 838; Anno. 54 A.L.R. 1504, 1513-1514; Anno. 82 A.L.R. 1184, 1186). The specific prohibition was found in Business and Professions Code section 2393 and such practice was denounced as a misdemeanor by section 2429. (Section references are to the Business and Professions Code unless otherwise indicated.) Cogent reasons, as we hereinafter set out, prompted the adoption of amendatory legislation in 1953 (Calif. Stats. 1953, ch. 1034).

Modern medical practice has tended more and more to specialize, which in turn leads to group practice. Particularly in the metropolitan centers one finds specialists such as internists, pathologists, obstetricians, pediatricians, gynecologists, urologists, neurologists and psychiatrists, closely associated with the general practitioner or the surgeon. The Legislature recognized that to continue the requirement that the names of all of the physicians and surgeons in a medical group be shown, and to prohibit the group being identified as a medical group, would make increasingly difficult and cumbersome the conducting of a group practice of medicine.

Many physicians and surgeons had sought to overcome this prohibition by organizing a private pay clinic under the provisions of the Clinic Act (Health and Safety Code sec. 1207, now repealed). This act permitted duly licensed members of the healing arts to practice under their respective licenses and under their own names in private pay clinics. However, the Clinic Act in itself did not then and does not now authorize the practice of medicine under a fictitious name; in fact, it does not relate to the practice of medicine as such. Therein are found direct prohibitions against interpreting any of its provisions as authorization to practice any of the healing arts. For example, Health and Safety Code section 1202 describes a clinic as a place where advice, diagnosis, treatment, medicines, etc., may be furnished to persons not residing or confined therein. There is no question that a licensed clinic is not authorized to practice medicine, for Health and Safety Code section 1205 (formerly section 1214) specifically provides that the act does not regulate, govern, or affect in any manner the practice of medicine, surgery, or osteopathy by any person duly licensed to engage in such practice, and further it does not repeal, alter, modify or affect *any act* defining or governing or regulating the practice of medicine, surgery, or osteopathy.

In order to crystallize the provisions of the law concerning the practice of medicine under a fictitious name, a revision and continuation of the Clinic Act, as well as an amendment to the sections of the Medical Practice Act relating to practice under a fictitious name was accomplished by the Legislature at its 1953 session. The Clinic Act was amended by prohibiting the issuing of new licenses to any group desiring to operate private pay clinics (Calif. Stats. 1953, ch. 1098, sec. 3) and the Medical Practice Act was amended by amending section 2393 (Calif. Stats. 1953, ch. 1034, sec. 1) to read as follows:

"The use of any fictitious, false or assumed name, or any name other than his own, by the holder of any certificate, either alone or in conjunction with a partnership group, in any sign or advertisement in connection with his practice or in any advertisement or announcement of his practice, or in any public announcement of his practice, constitutes unprofessional conduct within the meaning of this chapter. Holders of physician's and surgeon's certificates and holders of certificates to practice chiropody issued under this chapter may practice, within the scope of their respective certificates, in partnerships or groups of physicians and surgeons or of chiropodists, respectively; provided, that after September 30, 1953, no such partnership or group shall be formed or organized under any name except a name that includes the surname of one or more members of the partnership or group followed by the words 'Medical Group' or 'Chiropodist Group.' "

Thus, physicians and surgeons practicing as a medical group may not organize a private pay clinic. However, they may now practice in a group under a fictitious name in accordance with the express provisions of section 2393, authorizing physicians and surgeons to associate with each other (but not with licentiates of the healing arts carrying certificates authorizing practice other than as physicians and surgeons) and to use a fictitious name. Inferentially, it might be stated that this is also true in respect to chiropodists who receive their certificates to practice from the Board of Medical Examiners, except that they may only form a group or partnership with other licensed chiropodists and they will use the words "Chiropodist Group" rather than "Medical Group."

Many inquiries have been made to the Board of Medical Examiners as to whether a group of physi-

cians and surgeons may practice under any fictitious name provided that such partnership was formed and said name was adopted prior to September 30, 1953. These inquiries are occasioned because of the insertion in section 2393 of the phrase "provided, that after September 30, 1953, no such partnership or group shall be formed or organized under any name except a name that includes the surname of one or more members of the partnership or group followed by the words 'Medical Group.' " Some have concluded therefrom that, after the effective date of the amendment (September 9, 1953) and prior to September 30, 1953, they would be permitted to form a partnership and to use any fictitious name they wished, provided that such partnership was formed and such name was actually in use prior to September 30. We must agree that insofar as this phrase is concerned, the section is rather inaptly worded. Nevertheless, we cannot read such permission into the quoted phrase. Nowhere therein is found an express exemption from the prior prohibition of the use of a fictitious name. The quoted provision itself issues no statutory permission to physicians and surgeons to use any type of fictitious name as long as it is adopted subsequent to the effective date of the amendment and prior to September 30, 1953. Further, the first paragraph of the section reiterates the former provisions and clearly expresses a prohibition against practice under any fictitious name, this prohibition being modified by the "subsequent to September 30" provision. One must conclude that statutory permission to use any fictitious name prior to September 30, 1953, is forbidden to physicians and surgeons by the well known doctrine of statutory construction that the mention of one thing excludes those not mentioned (*expressio unius est exclusio alterius*).

It is urged that the Clinic Act has heretofore permitted, and under the recent amendments permits, group practice under a fictitious name. As we have heretofore indicated, views contrary to those we express herein have been urged because of a belief that the operation of a clinic entails the practice of medicine. We cannot read such authorization into the Medical Practice Act through any provision found in the Clinic Act. In fact, the Clinic Act states with as much directness and forcefulness as possible that no modification is made of the Medical Practice Act (Health and Safety Code sec. 1205). A careful reading of the Clinic Act, and particularly Health and Safety Code sections 1202 and 1205, will quickly dispel such erroneous views.

Be that as it may, whatever doubt might have existed has now been completely removed since no longer is there any permission for the forming of new private pay clinics. Henceforth physicians and surgeons who are engaged in private practice cannot so engage under the guise of newly forming and operating a private pay clinic.

It is well to stress at this point that physicians and surgeons who may now be operating private pay clinics under the provisions of section 3 of chapter 1098 of the Statutes of 1953, should ever be alert to a separation of the actual clinic operation from their practice as physicians and surgeons. As to the latter, such practice must be conducted under the individual names of the physicians and surgeons as appearing on their certificates, or under a fictitious name of the type set forth in section 2393. Nor may any of the partners so practicing medicine under a fictitious name be other than physicians and surgeons with unrevoked or unsuspended certificates issued by the Board of Medical Examiners or the Board of Osteopathic Examiners.